

00-04135

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove the non-permit pages 1 and 2 and file with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or disposition.

IMPORTANT: If item 21 is marked on item 18 above, injury, or other traumatic event, the medical examiner must be notified and a medical certification must be completed.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 11611

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) Lillian Magdalene Adams		2a. DATE OF DEATH MONTH DAY YEAR 04-13-1986		2b. HOUR 6:33A M	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 01-22-1908		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.	
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) telephone operator		12b. KIND OF BUSINESS OR INDUSTRY telephone co.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frank P. Heck		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Shaffer		13e. STREET ADDRESS / ZIP CODE 214 N. Lee Street/21502			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 232-07-7616		17. INFORMANT ADDRESS Mr. Robert J. Adams, Cumberland, MD - son			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>two weeks</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Senile dementia</u>							
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>October 9</u> , 19 <u>84</u> , to <u>April 13</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>April 6</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (did not) view the body after death.							
22b. SIGNATURE <u>W. Naumann</u>		DEGREE <u>M.P.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-14-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Walter Naumann MD		22e. ADDRESS Accident MD 21520					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 04-15-1986		23c. NAME OF CEMETERY OR CREMATORY Kalbaugh Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Elk Garden WV	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502				25a. DATE REC'D. BY REGISTRAR APR 18 1986			
				25b. REGISTRAR'S SIGNATURE [Signature]			

BP



00-02945

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

REG. NO.

1 1 6 1 2

1. DECEASED NAME (TYPE OR PRINT) George Edward Artice			2a. DATE OF DEATH MONTH DAY YEAR 4/6/1986		2b. HOUR 5:09 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 1/28/1939	6. AGE (IN YEARS (LAST BIRTHDAY)) 47 YRS	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.		
10. CITY OR TOWN OF DEATH Oakland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett County Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Planer Operator	12b. KIND OF BUSINESS OR INDUSTRY Lumber Co.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 3a. STATE Maryland		13b. COUNTY Garrett	13c. CITY OR TOWN Friendsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Box 183, Sawmills Lane 21531
14. FATHER'S NAME FIRST MIDDLE LAST Charles Richard Artice		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie - Coddington			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --	17. INFORMANT ADDRESS Box 183 Mrs. Charlotte Artice Friendsville, MD 21531			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>status epilepticus</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic hypernephroma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>June 1985</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>None</u>					
19a. DATE OF OPERATION <u>June 85</u>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>hypernephroma</u>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>85</u> to <u>4/6/1</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4/3/1</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Thurgood A. Kaiser</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>4/7/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>KAISER</u>		22e. ADDRESS <u>311 N 4th Suite 3 Oakland</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE April 9, 86	23c. NAME OF CEMETERY OR CREMATORY Steele Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Friendsville, Garrett, MD		
24. FUNERAL DIRECTOR NAME <u>W. Lynn Newman</u>		ADDRESS <u>Grantsville, MD</u>		25a. DATE REC'D. BY REGISTRAR <u>APR 9 1986</u>	
		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			



LIBRARY

ADDITIO NOTOS

00-03486

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

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DHMH - 17
(VR A15 ME (5))1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 6 1 3

1. DECEASED NAME (TYPE OR PRINT) Arlie Ray BLAKE				2a. DATE KNOWN OF DEATH MONTH 4 DAY 10 YEAR 86 HOUR 2 P P			
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH Dec. DAY 12 YEAR 1913	6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	IF UNDER 1 YR. MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN 	2c. DATE PRONOUNCED DEAD MONTH 4 DAY 10 YEAR 86 HOUR 04 P 5P	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7c. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett MD	
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 1 Box 355			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Recapper		12b. KIND OF BUSINESS OR INDUSTRY Tire
13a. STATE Maryland				13b. COUNTY Garrett	13c. CITY OR TOWN Oakland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS Rt. 1 Box 355 21550
14. FATHER'S NAME FIRST Charles MIDDLE LAST Hayes				15. MOTHER'S MAIDEN NAME FIRST (unknown) MIDDLE LAST Blake			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES) WW II		16b. SOCIAL SECURITY NO. 219-03-8106		17. INFORMANT ADDRESS Mrs. Elizabeth Blake - same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Maceration of structures of right neck DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. Self-inflicted 20 guage shotgun blast to neck (b) " DUE TO, OR AS A CONSEQUENCE OF (c) " APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>		M.D.		MEDICAL EXAMINER		DATE SIGNED 4-10-1986	
EXAMINER'S NAME (TYPE OR PRINT) James H. Feaster, Jr., M. D.		ADDRESS 107 S. 2nd. St., Oakland, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/13/86		23c. NAME OF CEMETERY OR CREMATORY Garrett Memorial Gardens		23d. LOCATION CITY OR TOWN Oakland COUNTY Garrett STATE Maryland	
24. FUNERAL DIRECTOR NAME Durst ADDRESS Durst Funeral Home - Oakland, Maryland 21550				25a. DATE REC'D. BY REGISTRAR APR 14 1986		25b. REGISTRAR'S SIGNATURE	

0-03805

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. There please remove the top papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 6 1 1 6 1 4 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Edith Othella Butler				2a. DATE OF DEATH MONTH DAY YEAR 3/20/1986				2b. HOUR 4:15 PM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2/2/1910		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett County MD			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Goodwill Mennonite Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
10. CITY OR TOWN OF DEATH Grantsville		13a. STATE Maryland		13b. COUNTY Garrett		13c. CITY OR TOWN Accident		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Main Street 21520			
14. FATHER'S NAME FIRST MIDDLE LAST Melchoir - George				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louisa - Smearman				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No ---				16b. SOCIAL SECURITY NO. 218-34-4376	
17. INFORMANT ADDRESS Route 2, Box 6				17. INFORMANT Arthur Butler, Jr.				17. INFORMANT Accident, MD 21520					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular arrest DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Brain Syndrome years DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3-19-1986 to 3-20-1986 that (I) (we) last saw the deceased alive on 3-19-1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE George B. Stoltzfus, M.D.				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-21-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George B. Stoltzfus, M.D.				22e. ADDRESS Box 67; Friendsville, Maryland 21531									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3/23/86		23c. NAME OF CEMETERY OR CREMATORY Grantsville Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Grantsville, Garrett, MD			
24. FUNERAL DIRECTOR NAME A. Lynn Newman				ADDRESS Grantsville, MD				DATE REC'D. BY REGISTRAR MAR 31 1986		25b. REGISTRAR'S SIGNATURE Erickson-Randall			

BP

CHIEF JAW

20% COTTON



00-05313

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. 1 6 1 5

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Walter Webster COLLIER			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 4 28 86		2b. HOUR 520 P M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 5-4-1894	6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4 28 86
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. CITY OR TOWN OF DEATH Grantsville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Goodwill Mennonite Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer	
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN LaVale	
14. FATHER'S NAME FIRST MIDDLE LAST Tarleton O. Collier		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Weller		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes	
16b. SOCIAL SECURITY NO. WW 1		17. INFORMANT Ruth C. Fitzpatrick, LaVale, MD		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Chronic heart failure (c) Arteriosclerosis, generalized	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Carcinoma of prostate with metastases; Fractured left hip.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 10 P.M. 4-26-86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Turned in bed and fractured left hip.	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Nursing Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Dorsey Hotel Rd. Grantsville Garn. Md	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>		TITLE (SPECIFY) DEPUTY		DATE SIGNED 4-28-1986	
EXAMINER'S NAME (TYPE OR PRINT) ADDRESS James H. Feaster, Jr., M. D. 107 S. 2nd. St., Oakland, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-1-86		23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery	
24. FUNERAL DIRECTOR <i>James H. Feaster, Jr.</i>		ADDRESS Grantsville, MD		25a. DATE REC'D. BY REGISTRAR MAY 1 1986	
25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25M
 BP
DHMH - 17
(VR A15 ME (5))

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100-4213

00-03806

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the signature of the physician be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Department of Health and Mental Hygiene with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. DECEASED NAME (TYPE OR PRINT) Charlotte Ellen DeWitt					2a. DATE OF DEATH MONTH DAY YEAR March 20, 1986			2b. HOUR 1:18a M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 26, 1999		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.				
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett County Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Maryland					13b. COUNTY Garrett		13c. CITY OR TOWN Oakland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Lutian DeWitt					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Elizabeth Sanders					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214-12-3394		17. INFORMANT ADDRESS Mrs. Evelyn Welch Rt. 5 Box 105-A Oakland Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> (c) <u>Renal Failure</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>Weeks</u> <u>Months</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Arteriosclerosis</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 19 81</u> to <u>Mar 20 86</u> , that (I) (we) last saw the deceased alive on <u>Mar 19 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Thomas Mance DO</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/20/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Tom Mance, DO				22e. ADDRESS 3 South Third Street Oakland, Md. 21550						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/22/86		23c. NAME OF CEMETERY OR CREMATORY Gortner Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Oakland Garrett Maryland				
24. FUNERAL DIRECTOR NAME Bradley A. Stewart				ADDRESS 32 S. 2nd St. Oakland, Md.		25a. DATE RECEIVED BY REGISTRAR MAR 31 1986		25b. REGISTRAR'S SIGNATURE		



00-05679

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86
REG. NO.

11617

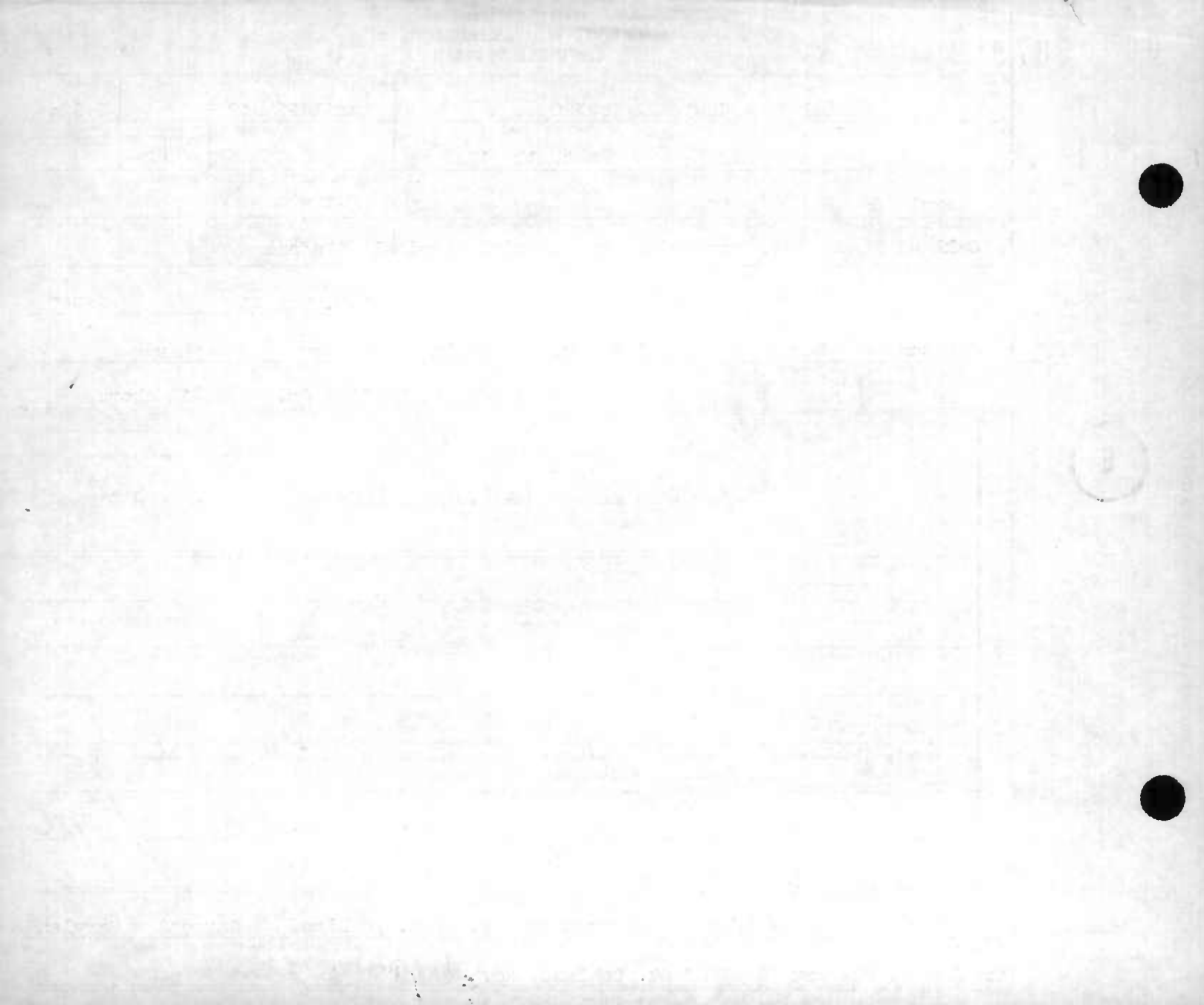
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
Daniel Guy DeWITT			April 25, 1986			8:58a M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Male	White	Oct. 17, 1985	YRS 6			DAYS 8		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9. BALTIMORE CITY OR COUNTY OF DEATH	10. CITY OR TOWN OF DEATH						
Maryland	Garrett	Oakland						
11. CITIZEN OF WHAT COUNTRY?	12. USUAL OCCUPATION	13. KIND OF BUSINESS OR INDUSTRY						
USA	Infant	BOA Garrett County Memorial Hospital						
14. CITY OR TOWN OF DEATH	15. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION	16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
Oakland	BOA Garrett County Memorial Hospital	17a. STATE 17b. COUNTY 17c. CITY OR TOWN						
MD.		18a. WVa. 18b. Grant 18c. Bayard						
19. FATHER'S NAME	20. MOTHER'S MAIDEN NAME	21. STREET ADDRESS / ZIP CODE						
Jackson Lee DeWitt, Jr.	Pamela Kay Sharps	P.O. Box 43 26707						
22. WAS DECEASED EVER IN U.S. ARMED FORCES?	23. SOCIAL SECURITY NO.	24. INFORMANT ADDRESS						
no	None	Jackson L. DeWitt, Jr. See #13 above						
25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								26. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) Respiratory Arrest								
DUE TO, OR AS A CONSEQUENCE OF (b) Werdnig-Hoffmann Disease								10 min.
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:								
27a. DATE OF OPERATION			27b. CONDITION FOR WHICH OPERATION WAS PERFORMED			28a. AUTOPSY?		28b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
29a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			29b. TIME OF INJURY			29c. HOW INJURY OCCURRED		
			HOUR A.M. MONTH DAY YEAR			ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2		
			P.M. 19					
30a. INJURY OCCURRED			30b. PLACE OF INJURY			30c. LOCATION		
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			(AT HOME - STREET, FACTORY, OFFICE, FARM, ETC.)			CITY OR TOWN COUNTY STATE		
31. I certify that (I) (the hospital) attended the deceased from birth, 19 to 4/25, 1986, that (I) (we) last saw the deceased alive on 4/1, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
32a. SIGNATURE						32b. DEGREE		32c. DATE SIGNED
Karl E. Schwalm						MD		4/25/86
33a. PHYSICIAN'S NAME (TYPE OR PRINT)						33b. ADDRESS		
Karl E. Schwalm						Oakland, MD		
34a. BURIAL, CREMATION, REMOVAL (SPECIFY)			34b. DATE		34c. NAME OF CEMETERY OR CREMATORY		34d. LOCATION	
Burial			4/27/86		Garrett Co Mem. Gdns.		CITY OR TOWN COUNTY STATE	
					Oakland		Garrett Maryland	
35. FUNERAL DIRECTOR						36. DATE REC'D. BY REGISTRAR		37. REGISTRAR'S SIGNATURE
NAME ADDRESS								
Bradley A. Stewart 32 S 2nd St. Oakland, Md.						MAY 06 1986		G. A. Davidson

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1E, sign any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8611618
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement for death certificate to be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked as Item 25, this is a serious injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)		FIRST Dorothy		MIDDLE H.		LAST Fazenbaker		2a. DATE OF DEATH MONTH 4/13/86		YEAR 7:45 P.M.	
3. SEX M MALE Female		4. RACE White		5. DATE OF BIRTH MONTH 8/16/1902		DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7b. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own home	
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett XX County Memorial Hospital		12c. STREET ADDRESS / ZIP CODE Route 1 21539		13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13b. CITY OR TOWN Lonaconing		13c. COUNTY Garrett	
14. FATHER'S NAME FIRST Andrew		MIDDLE ---		LAST Bittinger		15. MOTHER'S MAIDEN NAME FIRST Rebecca		MIDDLE ---		LAST Burkholder	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT Box 52 Mrs. Lottie Greene Frostburg, MD 21532		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 minute</u> <u>15 years</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <u>4-1-</u> 19 <u>86</u> , to <u>4-13</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>4-8-</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>W. Naumann</u> M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED <u>4-15-86</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Walter Naumann</u> M.D.		22e. ADDRESS <u>Accident + MD 21520</u>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>4/17/86</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Robeson Cemetery</u>	
23d. LOCATION CITY OR TOWN <u>Avilton</u>		23e. COUNTY <u>Garrett</u>		23f. STATE <u>MD</u>		24. FUNERAL DIRECTOR <u>D. Lynn Neuman</u>		25a. DATE REC'D. BY REGISTRAR <u>APR 24 1986</u>		25b. REGISTRAR'S SIGNATURE <u>John Barker</u>	



0-03540

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 11619
REG. NO.1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Melda B. Friend			2a. DATE OF DEATH MONTH DAY YEAR 04-08-1986			2b. HOUR 9:20P _M			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 05-11-1910		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.			
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE MD				13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Robert B. Riffle				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie Kisner					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-07-1421		17. INFORMANT ADDRESS Mrs. Carolyn J. Gaus, Cumberland, MD - daughter					
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Resistant UTI</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>x2M</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>several days</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cerebrovascular stroke</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 85</u> , 19 <u>85</u> , to <u>April 8</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4/8/86</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>4/9/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 04-11-1986		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD			
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove all "F" and "D" from the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18 showing injury, or other traumatic injury, the medical examiner must be notified at once.

1075

ONTO MEXICO

REBIL MOT TO 8000



8611620
REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Lula		Jane		GLOTFELTY				April 18, 1986								11:15aM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.							
Female		White		May 27, 1912		73		MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH										MD.	
Maryland		USA				Garrett											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Oakland		Garrett County Memorial Hospital		Homemaker		Home											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE									
West Virginia		Preston		Horseshoe Run				Rt. 1 Box 313-A								99999 26769	
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		FIRST		MIDDLE		LAST			
Charles		F.		Kelley				Blanche		Ellen		Benson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
no		217-18-4364		Nancy Sisler		See #13 above											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
		Metastatic Breast Cancer						Months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		Renal Failure															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
		P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from 1984, 19, to April 18, 1986, that (I) (we) lost		22b. SIGNATURE		DEGREE		22c. DATE SIGNED											
saw the deceased alive on April 18, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated		15		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		4/18/86											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS															
Robert Goralski, MD		311 N. Fourth Street Oakland, Md. 2155															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Cremation		4/20/86		Penn Cremation Serv.		Pittsburgh Allegheny PA.											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Bradley A. Stewart		32 S 2nd St. Oakland, Md.		APR 25 1986		Julia Davidson-Randall											

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

50540-00

00-04628

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 1 6 2 1
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Lillian Elizabeth GROVES		2a. DATE OF DEATH MONTH DAY YEAR April 13, 1986		2b. HOUR 11:40a.m.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 25, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.			
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett County Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lin. Vocational		12b. KIND OF BUSINESS OR INDUSTRY Nursing	
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 690 Fayette St. 21502	
14. FATHER'S NAME FIRST MIDDLE LAST Jesse Robert Groves		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Agnes Weekley		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 232-26-2718		17. INFORMANT ADDRESS Clelia Wendlandt see #13 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis - source unknown</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Severe anemia, GI bleed, COPD, organic brain syndrome</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3/30</u> 19 <u>86</u> , to <u>4/13</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4/13</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
27b. SIGNATURE <u>Margaret Kain MD</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		27c. DATE SIGNED 4-13-86	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>KAISER</u>				27e. ADDRESS <u>311 N 4th Suite 3 Oakland, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/16/86		23c. NAME OF CEMETERY OR CREMATORY Wilbur Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Wilbur Tyler West Virginia			
24. FUNERAL DIRECTOR NAME Bradley A. Stewart				ADDRESS 32 S 2nd St. Oakland, Md.		25. DATE REC'D BY REGISTRAR APR 22 1986		25b. REGISTRAR'S SIGNATURE <u>J. Davidson-Randall</u>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach this certificate to the funeral director's papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20% COTTON EMBL

MAINTENANCE

MAINTENANCE



00-00000

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-3564

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon #1 and 2 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 1 1 6 2 2 REG. NO.				
1. FOR STATE REGISTRAR					1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ada Clarice Howdershelt					2a. DATE OF DEATH MONTH DAY YEAR April 7, 1986			2b. HOUR 7:40am	
3. SEX female			4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR July 13, 1895			6. AGE (IN YEARS (LAST BIRTHDAY)) 90 YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W.Va.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Garrett County MD					
10. CITY OR TOWN OF DEATH Oakland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett Memorial Hospital					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife			12b. KIND OF BUSINESS OR INDUSTRY domestic			
13a. STATE W. Va.			13b. COUNTY Preston		13c. CITY OR TOWN Bruceton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rt. 3 26525			99999		
14. FATHER'S NAME FIRST MIDDLE LAST Samuel M. Funk					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Addie Dewitt									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 236-58-2058			17. INFORMANT ADDRESS Merril Nestor, Bruceton Mills, W.Va.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Complete Heart Block Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 12 hrs. years				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 19 85 to April 7 19 86, that (I) (we) last saw the deceased alive on April 7 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>[Signature]</i>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/7/86						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R A GONALSKI					22e. ADDRESS Oakland, Md									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-10-86		23c. NAME OF CEMETERY OR CREMATORY Red Rock Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Rowlesburg, Preston, WVa						
24. FUNERAL DIRECTOR NAME John H. Whitehair					ADDRESS Brandonsville, W.Va			25a. DATE REC'D. BY REGISTRAR APR 15 1986		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

00-04697

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN INL. ITEM 8. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
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DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH 6												REG. NO. 1 1 6 2 3			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Michael Eugene KELLEY												2a. DATE KNOWN OF DEATH MONTH DAY YEAR 4 21 86		2b. HOUR 19 10A	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 24, 1950		6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 36 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4 21 86		2d. HOUR 19 1235P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Garrett			
10. CITY OR TOWN OF DEATH Oakland				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 404 Seneca Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed				12b. KIND OF BUSINESS OR INDUSTRY None			
13a. STATE Maryland				13b. COUNTY Garrett		13c. CITY OR TOWN Mt. Lake Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 404 Seneca Ave.				21550	
14. FATHER'S NAME FIRST MIDDLE LAST Victor Harland Kelley						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Oretha Wava Lewis									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 220-58-2485		17. INFORMANT ADDRESS Victor H. Kelley See #13 Above									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Cerebral Aneurysm DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>				M.D. James H. Feaster, Jr., M. D.				MEDICAL EXAMINER 107 S. 2nd. St., Oakland, Md.				DATE SIGNED 4-21-1986			
EXAMINER'S NAME (TYPE OR PRINT) James H. Feaster, Jr., M. D.				ADDRESS 107 S. 2nd. St., Oakland, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 4/24/86		23c. NAME OF CEMETERY OR CREMATORY Garrett Co. Mem. Gdns.				23d. LOCATION CITY OR TOWN COUNTY STATE Oakland Garrett Maryland					
24. FUNERAL DIRECTOR NAME Bradley A. Stewart						ADDRESS 32 S2nd St. Oakalnd, Md.		25a. DATE REC'D. BY REGISTRAR APR 25 1986		25b. REGISTRAR'S SIGNATURE <i>Julia F. ...</i>					

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8611624

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Arthur William KIRKLAND			2a. DATE OF DEATH MONTH DAY YEAR April 9, 1986		2b. HOUR 1015P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 9, 1920		
6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7a. BIRTHPLACE (COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.				
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett County Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Principal		
12b. KIND OF BUSINESS OR INDUSTRY Education		13a. STATE Md.				
13b. COUNTY Garrett		13c. CITY OR TOWN McHenry		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE P.O. Box 218 21541		14. FATHER'S NAME FIRST MIDDLE LAST James ----- Kirkland				
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie Colvin Skinner		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				
16b. SOCIAL SECURITY NO. WW II 294-01-5249		17. INFORMANT ADDRESS Mary F. Kirkland, See #13 above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral vascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>severe atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>diabetes mellitus Type 1</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>years</u> <u>years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>myocardial infarction, Smoking</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) xxx attended the deceased from <u>6/1</u> 19 <u>85</u> to <u>4/9</u> 19 <u>86</u> , that (I) xxx lost saw the deceased alive on <u>4/9</u> 19 <u>86</u> , and that (I) xxx opinion death occurred on the date and hour and from the causes stated above, (I) xxx did not view the body after death.						
22b. SIGNATURE <u>Margaret Kaiser MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>4/10/86</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Margaret KAISER		22e. ADDRESS <u>311 N 45th St 3 Oakland</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 4/13/86		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		
23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.		24. FUNERAL DIRECTOR NAME ADDRESS Bradley A. Stewart Oakland, Maryland 21550				
25a. DATE REC'D. BY REGISTRAR APR 22 1986		25b. REGISTRAR'S SIGNATURE <u>Adrian...</u>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove burial papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

RECEIVED

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THIRTY

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00-03086

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 1 6 2 5
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mildred L. Knott			2a. DATE OF DEATH MONTH DAY YEAR April 5, 1986		2b. HOUR 1:45P M
3. SEX Female	4. RACE Cau	5. DATE OF BIRTH MONTH DAY YEAR Aug 8 1908		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.	
10. CITY OR TOWN OF DEATH Oakland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cuppett-Weeks Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY --	
13a. STATE WV		13b. COUNTY Mineral	13c. CITY OR TOWN Keyser	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Knott		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Knott			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --		17. INFORMANT ADDRESS Judy Rogers 107 S Main St Keyser, WV 26726	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) chronic renal failure; congestive heart failure, chronic					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes 5 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION ---		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ---		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2-28-19-86 to 4-5-19-86 , that (I) (was) last saw the deceased alive on 4-2- 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.					
22b. SIGNATURE W. Naumann		DEGREE M.D.		22c. DATE SIGNED 4-5-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Naumann		22e. ADDRESS Accident MD 21520			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/8/86		23c. NAME OF CEMETERY OR CREMATORY Philos Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Westernport Allegany MD		24. FUNERAL DIRECTOR NAME ADDRESS A. Craig Rotruck 85 S Main St Keyser, WV 26726			
25a. DATE REC'D. BY REGISTRAR APR 10 1986		25b. REGISTRAR'S SIGNATURE Jane Burton			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



00-05701

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 1 6 2 6
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Daisy Marie LEWIS			2a. DATE OF DEATH MONTH DAY YEAR April 25, 1986		2b. HOUR 3:00a M						
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 5, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9b. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.					
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett County Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Garrett 13c. CITY OR TOWN Oakland											
14. FATHER'S NAME FIRST MIDDLE LAST Richard Andrew Lewis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Icie Grace Spiker									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-24-6302		17. INFORMANT ADDRESS Harry V. Lewis See #13 above							
18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Gastric Cell Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>months</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a)											
19a. DATE OF OPERATION <u>12-2-85</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>weight loss</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (a) (this hospital) attended the deceased from <u>Oct 19 81</u> to <u>April 25 1986</u> , that (we) last saw the deceased alive on <u>April 25 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Thomas J. Mance</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas J. Mance				22e. ADDRESS 3 South Third Street Oakland, Md. 21550							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/27/86		23c. NAME OF CEMETERY OR CREMATORY Ferndale Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Oakland Garrett Maryland					
24. FUNERAL DIRECTOR NAME Bradley A. Stewart 32 S 2nd St. Oakland, Md.						25a. DATE REC'D. BY REGISTRAR MAY 06 1986		25b. REGISTRAR'S SIGNATURE <u>Julian Davidson</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified and a post-mortem examination may be required.

BP _____

2032 COTTON

DALE & WILSON



0-03508

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8611627
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		M	
Randy Allen Lewis		4-2, 1986			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	Caucasian	2-5-51 DAY YEAR	35	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
WV	U.S.A.		Garrett MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Oakland	Garrett Co. Memorial Hospital				
13a. STATE		13b. CITY OR TOWN	13c. STREET ADDRESS / ZIP CODE		
WV		Preston	Terra Alta YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> Aurora Ave., 26764 99999		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Harley M. Lewis		Elouise Yonker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO		17. INFORMANT	
Yes Vietam		234-82-7911		Elouise Y. Lewis, The Crossings Apt., Aurora Ave., Terra Alta, WV 26764	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					MINUTES
IMMEDIATE CAUSE (a) MYOCARDIAL FAILURE					
DUE TO, OR AS A CONSEQUENCE OF					HOURS.
Conditions, if any, which gave rise to immediate cause: (a), stating the underlying cause last. (b) METABOLIC ACIDOSIS					
DUE TO, OR AS A CONSEQUENCE OF					DAYS
(c) Renal Failure					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Hemorrhage due to Unresected Rupture; Cirrhosis of the Liver					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22. I certify that (a) (this hospital) attended the deceased from Dec 85, to April 2 1986, that (b) (we) last saw the deceased alive on April 2 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Mance		MD		4/3/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Thomas Mace		3 S. Third St., Oakland, Maryland 21550			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		4-5-86		Terra Alta Cemetery	
23d. LOCATION		23e. NAME OF CEMETERY OR CREMATORY		23f. LOCATION	
Terra Alta, WV		Terra Alta Cemetery		Terra Alta, WV	
24. FUNERAL DIRECTOR		24b. ADDRESS		24c. RECEIVED BY (HOSPITAL OR REGISTRAR'S SIGNATURE)	
John K. Whitehair		P.O. Box 46 Terra Alta, WV 26764		APR 11 1986	

1971, 2-1

12-7-71

Commission

Mr.

1971, 2-1

1971, 2-1

Mr.

Commission of Economic Enquiry

Mr.

1971, 2-1

1971, 2-1

Commission

Mr.

1971, 2-1

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Mr.

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Commission

Mr.

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0-02850

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 1 6 2 8
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Gay Harold LOUGHRIE			2a. DATE OF DEATH MONTH DAY YEAR April 4, 1986			2b. HOUR 5:37P M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 15, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 81		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		8b. CITIZEN OF WHAT COUNTRY? USA		9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.			
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett Co. Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Gen. Farming	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE W. Va.		13b. CITY OR TOWN Preston		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE Rt. 1 Box 95 26705			
14. FATHER'S NAME FIRST MIDDLE LAST Wesley Loughrie		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elesa Knutti							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 236-32-5205		17. INFORMANT ADDRESS Mrs. Elizabeth Loughrie - same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>RUL Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Organic Brain Syndrome</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>110</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Roger Lewis</i>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4-6-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Roger Lewis, M.D.		22e. ADDRESS Terra Alta, W. Va.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/7/86		23c. NAME OF CEMETERY OR CREMATORY Aurora Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Aurora Preston W. Va.			
24. FUNERAL DIRECTOR NAME Durst Funeral Home - Oakland, Maryland 21550				25a. DATE REC'D. BY REGISTRAR APR 08 1986		25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>			

MEDICAL CERTIFICATION

79

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-04554

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86
REG. NO.

11629

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILFORD D DeSales Manges		2a. DATE OF DEATH MONTH DAY YEAR April 20, 1986		2b. HOUR M	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR May 14, 1903	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS	
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett Memorial		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett County MD	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			

13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland	
14. FATHER'S NAME FIRST MIDDLE LAST Charles		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Beal		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-05-9258		17. INFORMANT ADDRESS 534 Maryland Ave. Mildred McConnell Cumberland, MD	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 h.	
DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE			
DUE TO, OR AS A CONSEQUENCE OF (c)			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: MYELOFIBROSIS; FX HIP; ISCHEMIC LEG			
19a. DATE OF OPERATION 3/18/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED FX HIP, ISCHEMIC	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from 3/18/86 to 4/20/86, that (I) (we) last saw the deceased alive on 4/20/86, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) see the body after death.			
22b. SIGNATURE F. PORCARO MD		22c. DATE SIGNED 4/21/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) F. PORCARO MD		22e. ADDRESS 257 N 4th ST OAKLAND MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/22/86		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Alleg. MD	
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24. FUNERAL DIRECTOR NAME Leasure-Stein Funeral Home, Inc.		25a. DATE REC'D. BY REGISTRAR APR 24 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson	
230 Baltimore Ave. Cumberland, MD 21502					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

100-100000

100-100000

100-100000



100-100000

100-100000

100-100000

100-100000

0-04638

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 6

REG. NO.

1 1 6 3 0

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. DATE OF DEATH			2c. DATE OF DEATH			2d. DATE OF DEATH		
Charles Alvin McCrum			4 7 86			4 7 86			4 7 86			4 7 86		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	2c. DATE OF DEATH			2d. DATE OF DEATH			2e. DATE OF DEATH		
Male	White	Jan. 23, 1902	84 YRS.			4 7 86			4 7 86			4 7 86		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH					
West Virginia			USA			WIDOWED			Garrett					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION			12b. KIND OF BUSINESS					
Oakland			Route #2, Cash Valley Road			Accountant			Lumber Co.					
13a. STATE			13b. CITY OR TOWN			13c. STREET ADDRESS			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
W. Va.			Preston			Aurora			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Route #1, Box 104 26705		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT		
Alvin A. McCrum			Margaret			No			234-86-0874			C. Bernard McCrum, See #13 above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I DEATH WAS CAUSED BY:												Years		
IMMEDIATE CAUSE (a) <u>Coronary artery disease</u>														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:														
(b) <u>Arteriosclerosis, generalized</u>														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?		
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED						
				HOUR A.M. MONTH DAY YEAR				ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2						
				P.M. 19										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY				21f. LOCATION						
				(AT HOME, STREET, FACTORY, FARM, ETC.)				STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED						
James H. Feaster, Jr., M. D.				DEPUTY MEDICAL EXAMINER				4-7-1986						
EXAMINER'S NAME				ADDRESS										
(TYPE OR PRINT)				107 S. 2nd. St., Oakland, Maryland										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION		
burial				4/9/86				Aurora Cemetery				Aurora, Preston, West Virginia		
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE						
NAME				ADDRESS										
Bradley A. Stewart				Oakland, Maryland 21550				APR 22 1986						

DMMH - 17
(VR A15 ME (5))

95010-0

UNION

WALKER

REBORN MOTION % 0.1



APR 22 1988

00-03485

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 11631
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Olivette (NMI) MULL			2a. DATE OF DEATH MONTH DAY YEAR April 10, 1986			2b. HOUR M 9:30P	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 21, 1895		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 90	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.	
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett Co. Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurses Aide		12b. KIND OF BUSINESS OR INDUSTRY Health Care	
13a. STATE Maryland		13b. COUNTY Garrett		13c. CITY OR TOWN Mt. Lake Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Madison J. Romesburg		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lelia Weckeniser		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 236-58-1706	
17. INFORMANT ADDRESS Rt. 5		17. INFORMANT Mrs. Mary Leighton - Oakland, Maryland 21550					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anasarca (Pleural Effusion, Ascites)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO, OR AS A CONSEQUENCE OF (b) Hepato-Renal Failure	6 months
	DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardio-Vascular Disease	Years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Diabetes Mellitus, Chronic Peptic Ulcer Disease**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from June 3, 1964 to April 10, 1986 , that (I) (we) lost saw the deceased alive on April 10, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Herbert H. Leighton, M.D.</i> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 11 Apr 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Herbert H. Leighton, M.D.				22e. ADDRESS Oak @ 5th Streets, Oakland, Maryland 21550			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/14/86		23c. NAME OF CEMETERY OR CREMATORY Somerset Memorial Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Somerset Somerset Penna.	
24. FUNERAL DIRECTOR NAME <i>Robert H. Leighton</i> ADDRESS Durst Funeral Home - Oakland, Maryland 21550				25a. DATE REC'D. BY REGISTRAR APR 14 1986		25b. REGISTRAR'S SIGNATURE <i>Davidson</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

00-04817

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 1 6 3 2
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) John Tressler RECKNER, Jr.			2a DATE OF DEATH MONTH DAY YEAR April 15, 1986			2b HOUR 7:20p _M			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Feb. 26, 1928		6 AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.			
10 CITY OR TOWN OF DEATH Oakland		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett County Memorial Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Conservationist		12b KIND OF BUSINESS OR INDUSTRY USDA-Soil Con.	
13a STATE Maryland			13b COUNTY Garrett		13c CITY OR TOWN McHenry		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST John Tressler Reckner, Sr.			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Catherine Brenneman						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1954-1956		17 INFORMANT Lillian Reckner		ADDRESS See #13 above			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic small cell CA of lung</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 mo	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>2/19/85</u> to <u>4/16/86</u> that (I) (we) lost saw the deceased alive on <u>4/15/86</u> 19 <u>86</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Margaret A. Kaiser MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c DATE SIGNED 4/16/86			
22d PHYSICIAN'S NAME (TYPE OR PRINT) KAISER						22e ADDRESS 311 N Fourth St. Oakland, Md. 21550			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 4/18/86		23c NAME OF CEMETERY OR CREMATORY Bittinger Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Bittinger Garrett Maryland		
24 FUNERAL DIRECTOR NAME Bradley A. Stewart 32 S 2nd St. Oakland, Maryland						25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove certificates to pages 1 and 2 and have them filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, a medical examiner must be called at once.

20% COMB 11888

CHIEF OF POLICE



00-03807

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 6

REG. NO. 1 1 6 3 3

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Andrew		David		SANDERS				3		27		86		19		239A	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	White	Jan. 1, 1983		3 YRS.						3		27		86		19	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland		USA				BALTIMORE											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Oakland		Garrett Co. Memorial Hospital		N/A		N/A											
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Maryland		Garrett		Oakland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		108 N. Third Street		21550							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
John		Nelson		Sanders		Denise		Rae		Philbrick							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		N/A		John N. Sanders - same as 13													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) (c)		Respiratory failure Probable Reye's Syndrome		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion		TITLE Deputy		DATE 3-27-86											
ACTUAL SIGNATURE		M.D.		MEDICAL EXAMINER		DATE SIGNED											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
James H. Feaster, Jr., M. D.		107 S. 2nd. St., Oakland, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		3/29/86		Oakland Cemetery		Oakland Garrett Maryland											
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Robert H. Durst		MAR 31 1986		Davidson-Rendall													
Durst Funeral Home - Oakland, Maryland 21550																	

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

00-04134

DIVISION OF VITAL RECORDS, 201 W. JEFFERSON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PLACE OF ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. JEFFERSON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BP
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 1 6 3 4		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lizzie Mae Sisler						2a. DATE KNOWN OF DEATH MONTH DAY YEAR 4 13 88						
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3/6/1894		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS 92 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4 13 88		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Garrett			
10. CITY OR TOWN OF DEATH Oakland			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Denner Road Manor Nursing Home						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY own home	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE Maryland		13b. COUNTY Garrett		13c. CITY OR TOWN Friendsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 1, Box 243		13f. ZIP CODE 21531		
14. FATHER'S NAME FIRST MIDDLE LAST James - Frazee						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie - Friend						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No						16b. SOCIAL SECURITY NO. 219-34-6593		17. INFORMANT Mr. Ray Sisler ADDRESS route 1, Friendsville, MD 21531				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute renal failure DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic cardio-vascular disease (b) Years DUE TO, OR AS A CONSEQUENCE OF (c) Years Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion.												
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>				M.D. James H. Feaster, Jr., M.D.				DEPUTY 107 S. 2nd. St., Oakland, Md.		DATE SIGNED 4-13-1986		
EXAMINER'S NAME (TYPE OR PRINT) James H. Feaster, Jr.				ADDRESS Grantsville, MD 21536								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial				23b. DATE 4/16/86		23c. NAME OF CEMETERY OR CREMATORY Blooming rose Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Friendsville, Garrett, MD			
24. FUNERAL DIRECTOR <i>D. Lynn Newman</i>				ADDRESS Grantsville, MD 21536				25a. DATE REC'D. BY REGISTRAR APR 18 1986		25b. REGISTRAR'S SIGNATURE <i>John A. Feaster</i>		

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00-04204

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 11635

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) McKinley Reed STEPHENS, Jr.			2a. DATE OF DEATH MONTH DAY YEAR April 17, 1986		2b. HOUR 6:10 P M	
3. SEX Male		4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 17, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.	
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett County Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Maintenance
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Garrett	13c. CITY OR TOWN Oakland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 983 E. High Street 21550	
14. FATHER'S NAME FIRST MIDDLE LAST McKinley Reed Stephens, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Irene Collins			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 218-12-5449		17. INFORMANT ADDRESS Mrs. Betty Stephens - same as 13		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>atherosclerosis</u>		<u>years</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>diabetes mellitus</u>		<u>years</u>

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: hepatic dysfunction

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>4/10/86</u> to <u>4/17/86</u> , that (I) (we) last saw the deceased alive on <u>4/17/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Margaret A. Kaiser</u> MD		22c. DATE SIGNED <u>4/18/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Margaret A. Kaiser, M.D.		22e. ADDRESS Fourth Street Oakland, Maryland 21550	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4/20/86	23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Oakland Garrett Maryland
24. FUNERAL DIRECTOR NAME ADDRESS Durst Funeral Home - Oakland, Md. 21550		25a. DATE REC'D. BY REGISTRAR APR 21 1986	
		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, states any injury, or other traumatic event, the medical examiner must be notified.

BP



00-04132

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 1 6 3 6
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lula E. Sybold		2a. DATE OF DEATH MONTH DAY YEAR 4-10-86		2b. HOUR 9:00 PM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 6, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.		10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dennett Manor Nursing Home	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY In Own Home		13a. STREET ADDRESS 135 N. Mechanic St.	
13b. CITY OR TOWN Cumberland		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STATE Maryland	
14. FATHER'S NAME FIRST MIDDLE LAST Irvin Imes		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Iames		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	
16b. SOCIAL SECURITY NO. 217-10-4899		17. INFORMANT Mrs. Thelma Cain, Cumberland, Md. Niece		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Vasculopathy DUE TO, OR AS A CONSEQUENCE OF (c) years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Oxygen Blain Syndrome, SH CVA					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. ALLOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I (this hospital) attended the deceased from 4-10-86 to 4-10-86 , that I (we) last saw the deceased alive on 4-10-86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I (we) did) (did not) view the body after death.					
22b. SIGNATURE George B. Stoltz		DEGREE MD		22c. DATE SIGNED 4-11-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George B. Stoltz		22e. ADDRESS Oakland, Md.		22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 4-13-86		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	
23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Md. 21502		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE John Swanson	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md. ADDRESS					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



RECEIVED



RECEIVED

RECEIVED

0-03622

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	11637			
1. DECEASED NAME FIRST MIDDLE LAST Edna Gladys Ruth WEEKS										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 4 13 86		2b. HOUR 517A		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan 22, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4 13 86		2d. HOUR 517A			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett							
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) (DOR) Garrett Co. Men. Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Education				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE Maryland		13b. COUNTY Garrett		13c. CITY OR TOWN Mt. Lake Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 15 O'Brien Street 21550						
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin F. Crane						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Civilla White								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 216-40-3241		17. INFORMANT ADDRESS Rayma Jeanne Weeks - same as 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Acute cardiac decompensation Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic cardio-vascular disease (c)										APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH Sudden Hours Years				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held the death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion				
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>				M.D. James H. Feaster, Jr., M. D.		MEDICAL EXAMINER 107 S. 2nd. St., Oakland, Md.				DATE SIGNED 4-13-1986				
EXAMINER'S NAME (TYPE OR PRINT) James H. Feaster, Jr.				ADDRESS 107 S. 2nd. St., Oakland, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPRINT) Burial				23b. DATE 4/16/86		23c. NAME OF CEMETERY OR CREMATORY Pleasant Valley Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE (rural) Oakland Garrett Md.				
24. FUNERAL DIRECTOR NAME <i>Robert M. Durst</i> ADDRESS Durst Funeral Home - Oakland, Maryland 21550						25a. DATE REC'D. BY REGISTRAR 'APR 15 1986		25b. REGISTRAR'S SIGNATURE <i>Robert M. Durst</i>						

MEDICAL CERTIFICATION

THE
OFFICE OF THE
ATTORNEY GENERAL
STATE OF NEW YORK
ALBANY, N. Y.
JAN 20, 1900
TO THE
COMMISSIONER OF THE
LAND OFFICE
SIR:
I have the honor to acknowledge the receipt of your letter of the 17th inst. in relation to the above matter.

Very respectfully,
J. B. ALLEN
Attorney General
Enclosed for the Commissioner of the Land Office are two copies of a report of the State Engineer, dated and captioned as above.

Very truly,
J. B. ALLEN
Attorney General
J. B. ALLEN
Attorney General
J. B. ALLEN
Attorney General

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove the top portion of this certificate and file it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other foul cause, a medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH				2b. HOUR			
FIRST MIDDLE LAST		MONTH DAY YEAR				HOURS MIN.			
Orpah Christina WICKER		4 29 86				5:55 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		White		MONTH DAY YEAR		97 YRS.		MONTHS DAYS HOURS MIN.	
17. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA				Garrett MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Oakland		136 N. Third St.				Teacher		Education	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Md.		Garrett		Oakland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		136 N. Third St. 21550	
14. FATHER'S NAME (FIRST MIDDLE LAST)					15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)				
Marshall Morgan Ashby					Sarah Beachy				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.				
no					166-32-1649				
17. INFORMANT					ADDRESS				
Personal Records					Oakland, Md. Stewart Funeral Home				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Ventricular Fibrillation									minutes
DUE TO, OR AS A CONSEQUENCE OF (b) Ischemic Heart Disease									years
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardio-Vascular Disease									years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
			P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION (STREET CITY OR TOWN COUNTY STATE)			
22a. I certify that (I) (this hospital) attended the deceased from June 27, 1985, to April 29, 1986, that (I) (we) last saw the deceased alive on April 23, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.									
22b. SIGNATURE						22c. DATE SIGNED			
Herbert H. Leighton, M.D.						30 April 86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			
Herbert H. Leighton, M.D.						Oak @ 5th Streets, Oakland, Maryland 21550			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN COUNTY STATE)		
Burial			5/2/86		Oakland Cemetery		Oakland Garrett Maryland		
24. FUNERAL DIRECTOR									
NAME					ADDRESS				
Bradley A. Stewart					32 S 2nd St. Oakland, Md.				
25a. DATE REC'D. BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
MAY 06 1986					Julia Davidson-Randall				

BP

100-73-20

9

APR 11 1950

RECORDS

00-05715

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 6

REG. NO.

1 6 3 9

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR																																			
Margaret R. WILKINS						4 23 1986			1045																																						
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE IN YEARS		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR																																	
Female		White		Feb. 2, 1893		93 YRS.						4 23 1986		11A _M																																	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH																																			
Paris, France				USA								Garrett MD.																																			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY																																			
Oakland				Cuppitt-Weeks Nursing Home				R.N.				Nursing																																			
USUAL RESIDENCE [IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION]																																															
13a. STATE				13b. CITY OR TOWN				13c. INSIDE CITY LIMITS?				13d. STREET ADDRESS																																			
Maryland				Garrett				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				Seventh and Alder St. 21550																																			
14 FATHER'S NAME								15. MOTHER'S MAIDEN NAME																																							
FIRST MIDDLE LAST								FIRST MIDDLE LAST																																							
John J. Ryan								Maria ----- Curtis																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?								16b. SOCIAL SECURITY NO.								17. INFORMANT ADDRESS																															
[YES, NO, OR UNKNOWN] [IF YES, GIVE WAR OR DATES]								no								555-34-0745 Sybil Branch Ft. Washington, Md.																															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																																															
PART I DEATH WAS CAUSED BY:																																															
IMMEDIATE CAUSE (a) Coronary artery disease																																															
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerosis, generalized																																															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																																															
(b) DUE TO, OR AS A CONSEQUENCE OF																																															
(c)																																															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d).																																															
19a. DATE OF OPERATION								19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY?																															
																YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH								21b. TIME OF INJURY								21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																															
								HOUR A.M. MONTH DAY YEAR																																							
								P.M. 19																																							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK								21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)								21f. LOCATION																															
																STREET CITY OR TOWN COUNTY STATE																															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																																															
ACTUAL SIGNATURE TITLE (SPECIFY)																																															
M.D. DEPUTY MEDICAL EXAMINER																																															
DATE SIGNED 4-23-1986																																															
EXAMINER'S NAME James H. Feaster, Jr., M. D. 107 S. 2nd. St., Oakland, Md.																																															
(TYPE OR PRINT) ADDRESS																																															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)								23b. DATE								23c. NAME OF CEMETERY OR CREMATORY								23d. LOCATION																							
Burial								4/26/86								Lakeview Cemetery								Winthrop Kennebec Maine																							
24 FUNERAL DIRECTOR																25a. DATE REC'D. BY REGISTRAR																25b. REGISTRAR'S SIGNATURE															
NAME ADDRESS																																															
Bradley A. Stewart 32 S 2nd St. Oakland, Md.																MAY 00 1986																Julia Davidson-Rogers															

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE SPACE PROVIDED. THE CHIEF MEDICAL EXAMINER, BALTIMORE, MD., SHALL BE NOTIFIED BY TELEPHONE OR IN WRITING. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, BALTIMORE, MD., WITHIN 72 HOURS OF DEATH. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT, PERMIT, PAGE 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MD., 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD., 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

2

00-04752

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					8 REC'D NO 11640				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mayme Anna Wright					2a. DATE OF DEATH MONTH DAY YEAR 4/18/1986			2b. HOUR 10:15 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4/28/1904		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett, MD			
10. CITY OR TOWN OF DEATH Oakland,		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE PA Maryland		13b. COUNTY Somerset		13c. CITY OR TOWN Addison		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Route 1, Box A1 15411	
14. FATHER'S NAME FIRST MIDDLE LAST Adam -- Hanft, Sr.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna B. Reichelt				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 168-50-4719		17. INFORMANT ADDRESS Mrs. Margaret Weimer 16 S. Oak St. 15436		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Influenza</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minute 1 Month 2 Months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Organic Brain Syndrome</u>									
19a. DATE OF OPERATION ---			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>7-13-</u> 19 <u>82</u> , to <u>4-18-</u> 19 <u>86</u> , that (I) (we) lost the deceased alive on <u>4-18-</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>W. Naumann</u> MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4-18-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Walter Naumann MD					22e. ADDRESS Accident MD 21520				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/21/1986		23c. NAME OF CEMETERY OR CREMATORY St. John's L. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Accident, Garrett, MD		
24. FUNERAL DIRECTOR <u>W. Leonard Dorman</u>					25. DATE REC'D. BY REGISTRAR IN REGISTRAR'S SIGNATURE APR 24 1986 <u>John Davidson-Randall</u>				

